

TOPICAL ANTI-ACNE MEDICATIONS

PREFERRED	Differin, Retin-A Micro, Tazorac, Tretinoin cream, Tretinoin gel
NON-PREFERRED	Atralin, Avita, Ziana

LENGTH OF AUTHORIZATION: 1 Year

NOTE: *All preferred and non-preferred agents will be subject to the DCH clinical PA criteria for members ages 21 years or older.*

PA CRITERIA:

For Differin, Retin-A Micro, Tazorac, and Tretinoin

- ❖ Approvable for members with a diagnosis of acne vulgaris
- ❖ Tazorac is also approvable for a diagnosis of plaque psoriasis.

For Atralin and Avita

- ❖ Approvable for members with a diagnosis of acne vulgaris who have failed therapy with a preferred tretinoin product available in the same formulation

For Ziana

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred products (clindamycin 1% gel and tretinoin 0.025% gel) are not appropriate for the member.

EXCEPTIONS:

- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **SXC Health Solutions at 1-866-525-5827**.

PA and APPEAL PROCESS:

- ❖ For online access to the PA process please go to www.gbp.georgia.gov, select the Provider Information tab, click on “view full text” in the Pharmacy Services box, click on “Prior Approval Process” in the list on the left.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limit please go to www.gbp.georgia.gov, select Provider Information, click on “view full list” in the Medicaid Provider Manuals box then select Pharmacy Services from the list shown.